**U.S. Department of Labor**

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**Issue Date: 22 November 2005Case No.: 2003-BLA-6576**

**In the Matter of:**

**Silas Mullins,**
**Claimant**

**v.**

**H & G Mining Company,**
**Employer**

**And**

**Director, Office of Workers' Compensation Programs,**
**Party-In-Interest**

## DECISION AND ORDER DENYING BENEFITS[1]

This proceeding arises from a claim for Benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §901 *et seq.* (hereinafter "the Act"). In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally disabled at the time of their deaths (for claims filed prior to January 1, 1982), or to the survivors of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as "black lung."

A formal hearing was held before me on April 12, 2005, in Abingdon, Virginia, at which time all parties were afforded full opportunity in accordance with the Rules of Practice and Procedure (29 C.F.R. Part 18) to present evidence and argument as provided in the Act and the regulations issued thereunder, set forth in Title 20, Code of Federal

[1] Part 718 of title 20 of the Code of Federal Regulations is applicable to the current claim, as it was filed after March 13, 1980, and the regulations amended as of December 20, 2000 (hereinafter "new regulations") are also applicable, as the current claim was filed after January 19, 2001. 20 C.F.R. §§ 718.2, 725.2.

Regulations, Parts 410, 718, 725, and 727. At that hearing, I admitted into the record Director's Exhibits 1-44,[2] ALJ Exhibits 1-2. Subsequently, the Claimant submitted exhibits 1-5 on June 10, 2005, and the Employer submitted exhibits 1-6 and 8-24 on July 14, 2005. The Claimant filed his post-hearing brief on October 5, 2005; the Employer filed its post-hearing brief on October 24, 2005.[3]

I have based my analysis on the entire record, including the transcript, exhibits, and representations of the parties, and given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.

## Jurisdiction and Procedural History[4]

Mr. Mullins (hereinafter the Claimant) has filed two previous claims. He filed his first claim on September 15, 1988, but withdrew this claim on January 24, 1989. The Claimant filed a second claim December 3, 1992, but the District Director (hereinafter the Director) denied the claim on June 7, 1993 for failure to establish pneumoconiosis. After reconsideration, the Director again denied the claim on November 23, 1993. The Claimant requested a hearing, and on October 11, 1995, Administrative Law Judge Lipson issued a Decision and Order denying the claim. The Claimant appealed, and the Benefits Review Board affirmed this decision in an unpublished decision dated August 19, 1996. (DX 1)

The Claimant filed the present claim for benefits on June 7, 2002. (DX 3) The Director issued a Proposed Decision and Order awarding benefits on June 24, 2003, finding H & G Mining (hereinafter the Employer) to be the responsible operator, and that the Claimant had established a material change in condition, that is, that he has totally disabling coal worker's pneumoconiosis. (DX 38) The Employer timely filed a request for formal hearing before the Office of Administrative Law Judges. (DX 39) The case was forwarded to this office on August 26, 2003 and subsequently assigned to Administrative Law Judge Solomon.

A hearing was scheduled for May 12, 2004 in Bristol, Virginia before Administrative Law Judge Solomon. However, on May 11, 2004, both parties requested a continuance, which Judge Solomon granted. The case was subsequently assigned to me, and I held a hearing in Abingdon, Virginia on April 12, 2005.

## Issues

1. Timeliness of the claim.

[2] The Employer withdrew a reading by Dr. Wiot that appears at DX 15 (Tr. 21).
[3] The Employer also filed a Motion to submit this brief out of time, which I have granted.
[4] Citations to the record of this proceeding will be abbreviated as follows: "Tr." refers to the Hearing Transcript of the April 12, 2005 hearing; "ALJX" refers to the Administrative Law Judge's Exhibits; "DX" refers to the Director's Exhibits; "CX refers to Claimant's Exhibits; and "EX" refers to Employer's Exhibits.

2. The length of coal mine employment.
3. Whether the Claimant has pneumoconiosis.
4. If so, whether the Claimant's pneumoconiosis arose out of coal mine employment.
5. Whether the Claimant is totally disabled.
6. Whether the Claimant's disability is due to pneumoconiosis.
7. Whether a material change in conditions has been established.

(DX 44; Tr. 23-25).

**Stipulations**

1. The Employer is the Responsible Operator. (Tr. 25)
2. The Claimant worked for at least 15 years in coal mines. (Tr. 24)

**Background**

The Claimant lives in Church Hill, Tennessee. (Tr. 27) He has been married to his wife, Tamra Mullins (nee Burke), for twenty years. (Tr. 34, DX 11) They have no children, and Mrs. Mullins does not work. (Tr. 34, DX 7 at 8) I find that the Claimant has one dependent for purposes of augmentation of benefits.

The Claimant testified that he worked in strip mines for approximately 20 years. (Tr. 28) He last worked in the state of Kentucky for Manning, but for less than one year. (Tr. 35) The last employer for which he worked one year or more is H & G Mining, located in Wise, Virginia. The Employer has agreed that the Claimant worked for fifteen years as a coal miner, which is supported by his Social Security earnings records. I find that the Claimant has established at least fifteen years of coal mine employment.

The Claimant's duties included running a rotary drill and a bulldozer. (Tr. 28) He used the rotary drill to drill into sandstone rock, shale rock and limestone. (Tr. 28) It was dusty work, and sometimes he could not see his hand in front of his face. (Tr. 28) Despite these conditions, he could not leave the drill he was running because the machine would have turned over. (Tr. 28)

The Claimant ran a bulldozer for approximately 4 years. (Tr. 30) For three of these years, his bulldozer did not have a cab on it; the dust covered the bulldozer blade, and irritated his eyes. (Tr. 30) This job involved minimal heavy lifting, but he did have to clean the tracks on the bulldozer every evening, which involved cleaning mud out of the rollers under the bulldozer with a shovel or an eight foot steel crowbar that weighed about 25 pounds. (Tr. 30-31) When the bulldozer broke down, he would also have to repair it. (Tr. 31) He stopped working because he was told his lungs were in bad shape. (DX 7 at 35)

The Claimant currently is on oxygen twenty-four hours a day, prescribed by Dr. Smith, his treating physician. (Tr. 32) He has been on oxygen for about 1.5 years. (Tr.

36) His condition at the time of the hearing was so bad that he could not walk without becoming short of breath, despite the oxygen. (Tr. 32) He also takes a pill for his breathing, which he drops in a blue container and inhales through his mouth. (Tr. 37)

The Claimant also has a blood pressure condition which he keeps under control with medication. (Tr. 36-37) He also has adult onset diabetes. (Tr. 37) He monitors his diet, and doctors have told him he needs to lose weight. (Tr. 37)

The Claimant did not smoke at the time of the hearing. (Tr. 33) He previously smoked, but quit in 1991, and several times before that. (Tr. 33) He has been taking Prednisone since 1990 to prevent his lupus from flaring back up. (Tr. 34-35)

**Timeliness**

The Employer contests the timeliness of the Claimant's claim, which was filed on June 7, 2002. A claim is timely filed by a miner if it is "filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner. . . ." 20 C.F.R. § 725.308(a). The regulations also provide that there is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. § 725.308(c). The Board has held that a determination of total disability due to pneumoconiosis must be "actually received" by the miner, and if so, there must be a finding that the miner was capable of understanding the report. *Adkins v. Donaldson Mine Co.,* 19 B.R.B. 1-34 (1993).

Several Circuit Courts have applied these regulations and determined that the statute of limitations applies to duplicative claims. However, both the Sixth and the Fourth Circuits have ruled that before a duplicative claim can be time-barred, the Employer must prove that the miner was adequately notified of his disease and his total disability before the statute of limitations can commence. *See Westmoreland Coal Co. v. Amick*, Case No. 04-1147 (4th Cir. Dec. 6, 2004) (unpub.), *Furgerson v. Jericol Mining Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.).

In this case, there is nothing in the exhibit record to indicate that the Claimant was diagnosed with a total disability due to pneumoconiosis at any time before he filed his application in June 2002. While the Employer stated in its Post Hearing Brief "there is evidence in the current and prior claim files that is sufficient to rebut the presumption under the Sixth Circuit's standard," the Employer did not point to any specific evidence to support its claim. Employer's Post Hearing Brief, October 24, 2005, at 27. During his deposition, the Claimant testified that he was told by a physician that he had black lung and that he was unable to return to work. But he could not name the diagnosing doctor, nor did he indicate that any physician ever informed him that he was *totally* disabled due to pneumoconiosis. (DX 7 at 36-40) These statements do not constitute reliable evidence of a medical determination of totally disabling pneumoconiosis or notification of that diagnosis.

I find that the Employer has not offered evidence sufficient to rebut the presumption of timeliness, and therefore the Claimant's claim for benefits is timely.[5]

*Medical Evidence*

Chest X-Rays[6]

| ***Exhibit No.*** | ***Date of X-ray*** | ***Reading Date*** | ***Physician/ Qualifications*** | ***Impression*** |
|---|---|---|---|---|
| DX 13 | 7/24/02 | 7/24/02 | Baker / B | Film underexposed, but quality reading of film by Dr. Goldstein is 1. Positive for pneumoconiosis; p/t, 5 zones, 1/0. No pleural abnormalities. Abnormality of cardiac size or shape. Post-op changes. |
| CX 4 | 7/24/02 | 9/20/03 | Alexander / B, BCR | Positive for pneumoconiosis; s/p, 6 zones, 2/1. Calcified granulomas in the right lung. Enlarged heart, sternotomy wires. |
| EX 9 | 7/24/02 | 12/5/03 | Wiot / B, BCR | Negative for pneumoconiosis. Calcified granuloma in right upper lobe, two small ones in right lower lobe. Calcified lymph nodes in right hilum. Not a manifestation of coal dust exposure. Previous sternotomy. |
| DX 14 | 9/30/02 | 10/9/02 | DePonte / B, BCR | Positive for pneumoconiosis; s/t, 6 zones, 1/1. Negative for pleural abnormalities. Status post median sternotomy, questionable CABG; calcified granulomas in right lung |
| EX 8 | 9/30/02 | 2/27/04 | Wiot / B, BCR | Film quality 2. Negative for pneumoconiosis. Previous sternotomy and coronary by-pass surgery. Calcified granuloma in right upper lung field and calcified granuloma at right base. Calcified lymph nodes in right hilum. Disc atelectasis at left base. |

[5] To the extent that the Employer is relying on evidence from the Claimant's previous claims, I am unable to consider any evidence from those claims that was not designated by the parties as part of their evidentiary submission under the new regulations. I made clear at the hearing that while the exhibits from the previous claim were admitted into the record, as required by the regulations, I would not consider any exhibits from the previous claims unless they were specifically designated by the parties. (Tr. 19-20)

[6] "B Reader" and "Board-certified radiologist" are designations that indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

| *Exhibit No.* | *Date of X-ray* | *Reading Date* | *Physician/ Qualifications* | *Impression* |
|---|---|---|---|---|
| EX 6 | 1/27/03 | 3/16/05 | Wheeler / B, BCR | Negative for pneumoconiosis. Remarkable for 1 cm nodule in lateral right apex compatible with granuloma more likely than tumor. Recommended CT scan. "Obesity contributes to hypoinflation and minimal discoid atelectasis both bases." Tiny calcified granuloma lower right mid lung compatible with healed TB or histoplasmosis. Tiny linear scare near right diaphragm dome. |
| CX 1 | 4/28/04 | 4/28/04 | Patel / B, BCR | Film grade II. Positive for pneumoconiosis, s/t, 1/1. Less than optimally inflated lungs. Bronchovascular congestion. Minimal scarring or atelectasis at lung bases. Prominent epicardial fat pads in both cardiophrenic angles. Scattered granulomatous lung calcifications and calcified right hilar lymph nodes. Heart normal to borderline enlarged. Prior sternotomy. |
| EX 11 | 4/28/04 | 5/6/05 | Wiot / B, BCR | Negative for pneumoconiosis. Ca, co. |
| EX 1 | 6/15/04 | 6/15/04 | Rosenberg | Negative for pneumoconiosis. Ca; status post coronary artery bypass graft, atelectasis on left, granulomatous disease, some in right mid lung field. |

## CT Scan Evidence

| *Exhibit No.* | *Date of CT Scan* | *Reading Date* | *Physician/ Qualifications* | *Impression* |
|---|---|---|---|---|
| EX 12 | 4/28/04 | 5/6/05 | Wiot / B, BCR | Negative for pneumoconiosis. Lung fields show emphysematous change. Slightly enlarged heart. |

## Pulmonary Function Tests

| *Exhibit No.* | *Date* | *Age/Ht* | *FEV1* | *FVC* | *MVV* | *Qualifying* |
|---|---|---|---|---|---|---|
| DX 13 | 7/24/02 | 49 / 67 ¼" | 1.64 | 2.6 | - | FEV1 qualifies |
| CX 1 | 4/28/04 | 51 / 68" | 1.49<br>1.83* | 2.46<br>2.90* | - | FEV1 and FVC on exercise qualify |

| *Exhibit No.* | *Date* | *Age/Ht* | *FEV1* | *FVC* | *MVV* | *Qualifying* |
|---|---|---|---|---|---|---|
| EX 1 | 6/15/04 | 51 / 68" | 1.32<br>1.35 | 1.99<br>2.05 | 52<br>60 | Yes |

* Score achieved post-bronchodilator.

Arterial Blood Gas Results

| *Exhibit No.* | *Date* | *Physician* | *pCO2 (rest)*<br>*pCO2 (exercise)* | *pO2 (rest)*<br>*pO2 (exercise)* | *Qualifying* |
|---|---|---|---|---|---|
| DX 13 | 7/24/02 | Baker | 36 | 64 | Yes |
| EX 1 | 6/15/04 | Rosenberg | 39.1 | 54.1 | Yes |

Biopsy Evidence

*Dr. Landon A. Colquitt*

The Claimant underwent a biopsy on April 22, 2002. Dr. Colquitt examined the Claimant's mediastinal lymph node, and wrote a surgical pathology report dated May 16, 2002. (CX 3) He identified the specimen as a paratracheal lymph node, and diagnosed sinus histiocytosis with carbonaceous pigment deposition and fibrocalcific anthrasilicotic nodules. Immunophenotyping analysis revealed no evidence of an aberrant B- or T-lymphoid population. Dr. Sides also reviewed the slides and agreed with Dr. Colquitt's interpretation.

*Dr. Everret Oesterling*

Dr. Oesterling, who is board-certified in anatomic pathology, clinical pathology and nuclear medicine, examined the tissue samples retrieved during the Claimant's biopsy, and wrote a report dated November 26, 2004. (EX 4 and 15) He also testified by deposition on April 21, 2005. (EX 15)

Dr. Oesterling explained that the hilar lymph nodes act as a filtration system, removing any foreign material in the lymphatic fluids as they leave the lung. Their only function is to remove particulate matter to prevent it from entering the body's circulation. (EX 4) Dr. Oesterling also explained that the lymph nodes are not primarily involved in gaseous exchange, and therefore a minimal quantity of dust in the lymph nodes is of no clinical significance. (EX 4) In diagnosing pneumoconiosis, Dr. Oesterling looks for carbonaceous material, black pigment with silica and silicate crystals, and levels of disease. (EX 5 at 13) He stated that he also needs to see lung tissue.

Dr. Oesterling noted that of all the tissue samples presented, none measured a full centimeter. Thus, the lymph nodes retrieved were small. In addition, he noted the

overall absence of black pigmentation. He described the predominant pale pink color and very modest quantities of black pigment on one of the tissue fragments. On the last tissue fragment on slide 1, he found somewhat nodular areas of pale pink tissue surrounded by modest quantities of black pigment, with normal lymphoid tissue. On a lower microscope power, he noted swirled pale pink areas with minimal anthracotic pigment. On a higher power, he saw collagen fibers, which he explained are scars. In the left aspect, he saw histiocytes containing modest quantities of black pigment with elongate needle-shaped bright silicate crystals and smaller less birefringent silica crystals. Dr. Oesterling stated that the origin of the black pigment was coal dust, but it was modest in amount and had elicited minimal fibrosis.

Dr. Oesterling found no enlarged lymph nodes. While the nodes he examined showed very modest quantities of black pigment, one of them had a fibronodular response to silica crystals. According to Dr. Oesterling, if there had been significant quantities of dust inhaled, these lymph nodes would be enlarged, markedly blackened, and contain extensive areas of fibrosis. But this was not the case. Dr. Oesterling acknowledged that the pigment in the nodes indicated limited dust exposure, but little likelihood of any pneumoconiosis due to mine dust inhalation, because it was rare to see relatively normal lymph nodes in the presence of significant coalworkers' pneumoconiosis.

## Medical Opinion Evidence[7]

### *Dr. Larry J. Foster*

Dr. Foster, who is board certified in internal medicine and pulmonary diseases, performed a biopsy on the Claimant on April 26, 2002, and followed up with him on May 29, 2002. (CX 5) He wrote a report detailing his findings, and he also testified by deposition on November 12, 2004. (CX 2)

Dr. Foster had sent the Claimant for a biopsy of his lymph nodes after seeing a spot on his CAT scan. The pathologist reported to Dr. Foster that the biopsy slides showed some changes of scarring, or carbonaceous pigment deposition and fibrocalcific anthrasilicotic nodules that were part of the Claimant's paratracheal lymph node. While Dr. Foster did not personally review the biopsy slides, he noted that the pathologist's diagnosis was consistent with damage caused by inhalation of coal dust. (CX 2 at 16, 22) Dr. Foster stated that if the abnormalities were due to granulomatous disease, he would expect to see either cascading or non-cascading granulomatous change, which he did not see on the Claimant's films. He felt that these changes were consistent with an occupationally induced abnormality. (CX 2 at 18)

According to Dr. Foster, the Claimant started smoking at a young age and quit at age 38. The Claimant's medical history also included lupus, and resultant long-term

[7] The Employer submitted a medical report by Dr. Dahhan. However, the Employer did not designate this report on its Evidence Exhibit List, and thus I have not considered it in this decision.

steroid therapy. Dr. Foster explained that lupus can cause a host of pulmonary ailments, including pleurisy, a pulmonary fibrosis type disease, pulmonary hypertension, acute pneumonia, and blood clots. (CX 2 at 23) The Claimant informed Dr. Foster that he had a lymph node biopsy in the past, which showed that he had lupus involving his lungs. (CX 2 at 23-24)

Dr. Foster explained that both lupus and advanced pneumoconiosis can cause interstitial lung disease, and that it would be hard to tell the difference between changes of pneumoconiosis and changes of lupus on x-ray. (CX 2 at 28-29) Although he had no way to determine if the abnormalities on the Claimant's x-rays and CT scan were caused by lupus or pneumoconiosis, he maintained that the pathology results from the biopsy indicated pneumoconiosis, or an occupationally induced disease. (CX 2 at 30, 32)

*Dr. Donald L. Rasmussen*

Dr. Rasmussen, who is board-certified in internal medicine and pulmonary diseases and a NIOSH B-Reader, examined the Claimant on April 28, 2004. (CX 1) He obtained a chest x-ray, pulmonary function studies, and arterial blood gas studies. Dr. Rasmussen reviewed the Claimant's medical, smoking and work histories; the Claimant presented with a fifteen year history of shortness of breath.

On physical examination of the Claimant, Dr. Rasmussen noted that he became markedly dyspneic with slight effort. The Claimant indicated that he wheezed when lying down, had sleep apnea, and used a C-PAP machine. Dr. Rasmussen noted that his chest expansion seemed reduced, and his breath sounds were moderately reduced. He noted fine late inspiratory Velcro crackles bilaterally, but no rhonchi or wheezes. The Claimant's heart tones were reduced. The Claimant's chest x-ray was interpreted by Dr. Manu Patel, who is dually qualified, and who noted pneumoconiosis 1/1, s, t throughout all lung zones, top normal to borderline cardiomegaly, and right ghon complex scarring or atelectasis of the right lower lung zone. An EKG showed poor R-wave progression, low amplitude R1, R/S1 equal to 1R, and RV1 greater than SV1 consistent with a right ventricular hypertrophy and possibly anterior myocardial infarction.

The Claimant's pulmonary function tests revealed a marked, partially reversible restrictive and obstructive ventilatory defect. His total lung capacity was reduced, and his single breath carbon monoxide diffusing capacity was markedly reduced.

Dr. Rasmussen reported marked resting hypoxemia. During a treadmill exercise study, the Claimant achieved 33% of his predicted maximum oxygen uptake. EKG and blood pressure responses were normal. His heart rate was excessive at 63% of the predicted maximum. Overall, the studies indicated very severe, totally disabling lung disease. According to Dr. Rasmussen, the Claimant does not retain the capacity to perform his last regular coal mine employment or to engage in any significant employment.

Dr. Rasmussen diagnosed coal worker's pneumoconiosis which arose out of the Claimant's coal mine employment. He based this opinion on the Claimant's history of exposure to coal mine dust and his x-ray changes consistent with the disease. The cause of this disease, according to Dr. Rasmussen, is coal mine dust exposure and cigarette smoking. Dr. Rasmussen cited several medical articles discussing mine dust induced emphysema, mine dust induced interstitial fibrosis, and silica exposure induced scleroderma. Dr. Rasmussen concluded that the Claimant's mine dust exposure must be a "primary and possibly secondary cause" of the Claimant's lung disease.

*Dr. Glen Baker*

Dr. Baker examined the Claimant on July 24, 2002 at the request of the Department of Labor. (DX 13) He noted that the Claimant had 20 years of surface mining work. Dr. Baker recorded the Claimant's medical history, which includes pneumonia, pleurisy, attacks of wheezing, heart disease, diabetes mellitus, and high blood pressure. He was diagnosed with discoid lupus in the 1970's, and was hospitalized for a heart attack and pneumonia. His past surgeries include coronary artery bypass graft and biopsy of a lymph node, which was positive for anthrasilicosis and carbonaceous material.

The Claimant's symptoms included wheezing, dyspnea, chest pain, and orthopnea; he became short of breath at night. On examination of the Claimant, Dr. Rasmussen noted that he was 67 ¼ inches tall and weighed 213 pounds. His chest x-ray showed coal worker's pneumoconiosis 1/0. His ventilatory study showed a moderate obstructive defect, and his arterial blood gas study showed moderate resting arterial hypoxemia. The exercise portion of the arterial blood gas study was contraindicated by the Claimant's ischemic heart disease. His EKG revealed an old anterior and inferior infarction.

Dr. Baker diagnosed coal worker's pneumoconiosis based on the Claimant's abnormal chest x-ray and his history of coal dust exposure. His other diagnoses included chronic obstructive pulmonary disease based on the Claimant's pulmonary function tests, moderate hypoxemia based on the Claimant's PO2, and ischemic heart disease based on the Claimant's acute heart attack and coronary artery bypass graft. For all respiratory impairments, Dr. Baker cited coal dust exposure as the etiology. With respect to the Claimant's chronic obstructive pulmonary disease and moderate hypoxemia, he also cited cigarette smoking and possibly the Claimant's cardiac condition as the etiology.

Dr. Baker concluded that the Claimant's respiratory impairment is moderate with a decreased FEV1, decreased PO2, and coal worker's pneumoconiosis. He felt that each of his diagnoses fully contributed to this impairment. According to Dr. Baker, the Claimant does not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. He based this opinion on the Claimant's FEV1 (49%) and PO2 (64) results.

*Dr. Michael D. Boggan*

Dr. Boggan examined the Claimant on May 3, 2002. (CX 5) He stated that the Claimant has had calcified nodes in his mediastinum for quite some time, and at the time of this appointment, he had a two centimeter noncalcified node in the peritracheal area. Dr. Boggan recommended a biopsy of the node, as it had grown in size. There were other calcified nodes in the Claimant's mediastinum, and Dr. Boggan felt that if this non-calcified node were due to the same process, it would also have calcified.

*Dr. Lawrence H. Repsher*

Dr. Repsher reviewed the Claimant's medical records and wrote a report detailing his findings on March 21, 2005.[8] (EX 2) He also testified by deposition on March 28, 2005. (EX 3) Dr. Repsher reviewed the newly submitted evidence, as well as evidence submitted in relation to the Claimant's previous claims. Dr. Repsher is board certified in internal medicine, pulmonary disease, and critical care; he is also a NIOSH B reader. (EX 14)

Dr. Repsher recorded the Claimant's 20 year history of working above ground at coal mines. The Claimant was a driller for 12 to 15 years, and operated a bulldozer. While some reports indicated that he smoked one pack of cigarettes a day for 12 years, quitting in 1991, another indicated that he smoked 1.5 packs a day for 17 or 19 years.

The records reflected that the Claimant has had controlled hypertension since 1987. He is increasingly severely obese. Past illnesses and treatments include discoid lupus treated with prednisone, a kidney biopsy, bilateral cataract extractions, renal lithiasis, pneumonia, deep vein thrombosis, heart attack leading to cardiac catheterization, and diagnosis of possible Prinzmetal's disease, lung biopsy, chronic peptic ulcer disease, another heart attack leading to a coronary artery bypass graft, hyperlipidemia, diabetes mellitus, and a mediastinoscopy revealing anthracosilicotic nodes.

Dr. Repsher reviewed the Claimant's past chest x-ray interpretations, finding them to be negative for pneumoconiosis but positive for calcification of hilar nodes and blunting of the left costophrenic angle, with distortion of the left hilum. Some readers noted cardiomegaly, emphysema, and calcified granulomas of both hila. He found the Claimant's pulmonary function tests to be invalid for medical interpretation due to extremely poor effort and cooperation. The arterial blood gases showed moderate to moderately severe hypoxemia, which Dr. Repsher attributed to the Claimant's coronary artery disease and probable hypertensive cardiovascular disease, with chronic left ventricular congestive heart failure.

Based on the negative x-ray interpretations, Dr. Repsher concluded that the Claimant has no radiographic evidence of coal worker's pneumoconiosis. According to Dr. Repsher, there is no histologic evidence of coal workers pneumoconiosis, as the earlier transbronchial lung biopsies showed no evidence of coal macules. Dr. Repsher

[8] Dr. Repsher submitted a letter dated June 22, 2005 indicating he did not rely on the August 13, 2003 report of Dr. Rasmussen when forming his opinion. (EX 23)

believed that the physicians did not resect the target node on mediastinal biopsy, since the nodes that were retrieved were 1 centimeter in diameter, some calcified, unlike the target node, which was 2.6 centimeters in diameter and not calcified. But in any event, Dr. Repsher explained that while mediastinal lymph nodes drain the lungs of debris that does not belong there (EX 3 at 48-49), a diagnosis of pneumoconiosis cannot be made based on a lymph node biopsy. Again, he noted that the Claimant's previous transbronchial lung biopsies failed to show any histologic evidence of pneumoconiosis, and only documented chronic left ventricular congestive heart failure.

Dr. Repsher found the Claimant's pulmonary function tests to be invalid for diagnosis due to his poor effort, and underlying chronic left ventricular congestive heart failure. Dr. Repsher likewise found no arterial blood gas study results indicative of pneumoconiosis. While these results qualify for disability under the DOL regulations, Dr. Repsher felt that they should be invalid for interpretation because scientific and DOL criteria instruct that arterial blood gas samples should not be drawn from a patient with congestive heart failure. He also pointed out that the exercise test documented severe cardiac disease and showed "no evidence of any clinically significant intrinsic lung disease," noting that the characteristic feature of lung disease is the inability of a patient to reach his anaerobic threshold. During his deposition, Dr. Repsher explained that the Claimant's tests showed hypoxemia, but that this was not caused by coal dust exposure. (DX 3 at 51) Instead, the Claimant's cardiovascular disease and coronary artery disease caused left ventricular congestive heart failure, which caused hypoxemia. The hypoxemia was not caused by exposure to coal mine dust.

Dr. Repsher concluded that the Claimant has evidence of chronic obstructive pulmonary disease (COPD) and that it could be due, at least partially, to coal dust exposure. (EX 3 at 31) However, statistically, according to Dr. Repsher, that would be very unlikely. Since COPD from coal dust exposure generally resolves within 12 months of cessation of exposure, Dr. Repsher felt that the Claimant's COPD had another etiology. According to Dr. Repsher, the degree of obstructive disease associated with inhalation of mine dust is so small that it is not clinically important or significant. (EX 3 at 32)

Dr. Repsher attributed the Claimant's condition to his other serious and potentially serious medical diseases and conditions, none of which are related to coal mine employment. In fact, he found coronary artery disease to be "less common" in miners due to the nature of their laborious work and restraints on cigarette smoking. Similarly, lupus, hypertension, diabetes, hyperlipidemia, and renal lithiasis have never been suggested or documented as being related to coal dust exposure. Dr. Repsher concluded that the evidence negated a finding of medical or legal pneumoconiosis, and found no material change in the Claimant's condition since 1994.

*Dr. David M. Rosenberg*

Dr. Rosenberg, who is board certified in internal, pulmonary and occupational medicine, examined the Claimant on June 15, 2004 at the request of the Employer. (EX

1) The Claimant complained of shortness of breath for 10 years and coughing spells to the point of vomiting. He occasionally produced sputum, but no wheezing. The Claimant's disability also interfered with his activities of daily living. He intermittently awakened at night with shortness of breath.

Dr. Rosenberg reviewed the Claimant's medical history, noting his medications and past surgeries, including his bypass surgery and mediastinoscopy with a lymph node biopsy, which showed the presence of anthracotic and silica deposition with some fibrosis. The Claimant had been treated for discoid lupus for 10 years, and had had the usual childhood illnesses, but not pneumonia, or congestive heart failure.

The Claimant had a smoking habit for about 5 years of a half-pack a day, quitting in 1991; he chews tobacco. The Claimant worked for 20 years in the mines, all on the surface. About 75% of his work was in an open cab operating a dozer or drill with minimal respiratory protection. The Claimant's work produced so much dust that he could not see the levers in front of his face. The Claimant did not consider this to be manual labor, as he only worked the levers within the cab. He quit in 1991 after having a heart attack.

On physical examination, the Claimant wore his oxygen. He had equal expansion of his chest with bilateral mild persistent rales. The Claimant's chest x-ray was reviewed by a B reader, and it showed cardiomegaly, granulomatous change, and atelectasis in the left costophrenic angle. His sternotomy wires were in place. Dr. Rosenberg noted that the Claimant's CAT scan was negative for micronodularity associated with past coal dust exposure. He noted basilar linear interstitial fibrosis, emphysema, and three small nodules. The Claimant's EKG revealed loss of anterior forces consistent with an old anterior myocardial infarction. His pulmonary function test scores were below predicted levels, with no bronchodilator response. His arterial blood gas study results worsened with exercise.

Dr. Rosenberg concluded that the Claimant, who stopped working in mines in 1991, would not have developed latent or progressive coal worker's pneumoconiosis after he left the mines. The Claimant had not developed any x-ray micronodularity or pulmonary massive fibrosis. Dr. Rosenberg felt that any linear changes described on the Claimant's x-ray do not represent medical coal workers' pneumoconiosis.

Dr. Rosenberg felt that the Claimant's worsening oxygenation was related to his underlying linear interstitial lung disease, which was not coal dust related, but was caused by lupus.

According to Dr. Rosenberg, the Claimant is totally disabled, and clearly could not perform his previous coal mine employment or similarly arduous work. However, Dr. Rosenberg maintained that this disability does not relate to either legal or medical pneumoconiosis. Nor did he believe that coal dust disease hastened the Claimant's condition in any way; he pointed to lupus as the etiology for his disorder. The Claimant's obstructive lung disease, according to Dr. Rosenberg, is unaffected by his coal dust

exposure. In fact, any anthracotic or silicotic findings within his mediastinal lymph node tissue do not relate to medical or legal pneumoconiosis. Lastly, Dr. Rosenberg stated that the Claimant's disability does not relate to coal dust exposure.

*Dr. Jerome Wiot*

The Employer submitted the deposition transcripts of Dr. Jerome Wiot, who is board-certified in radiology. (EX 10 and 22) As the Employer has submitted its allowed maximum of two medical reports, Dr. Wiot's testimony is only relevant as it pertains to his x-ray and CT scan interpretations. Dr. Wiot interpreted the Claimant's September 30, 2002 and July 24, 2004 films. (EX 8 and 9) He also reviewed several films from the Claimant's previous claim.[9]

Dr. Wiot explained that radiographically, coal worker's pneumoconiosis "invariably begins in the upper lung fields." (EX 10 at 12) If it appears on only one side, it almost invariably occurs on the right. Typically, but not always, he sees rounded opacities. If the disease has progressed, it moves to the mid and lower lung fields. He also looks for "egg shell calcifications," calcifications of the periphery of lymph nodes, rather than "mulberry" calcifications, which are seen with tuberculosis and histoplasmosis. However, Dr. Wiot pointed out that egg shell calcifications can also occur in sarcoid and treated lymphoma. He also looks for large opacities, which are masses of fibrosis that occur primarily within the upper lung fields. Dr. Wiot generally gives patients the benefit of the doubt when reading x-rays.

After reviewing the Claimant's x-rays, Dr. Wiot concluded that his condition has not changed at all. In Dr. Wiot's opinion, the calcified granulomas in the Claimant's upper and lower right lung zones are not related to coal workers' pneumoconiosis. (EX 10 at 35-36) These granulomas are totally calcified, which does not happen in coal workers' pneumoconiosis or silica. (EX 10 at 36) Likewise, the calcified lymph nodes are not of the type associated with coal workers' pneumoconiosis, as they are "so-called mulberry seed-type calcifications" instead of egg shell calcifications. Dr. Wiot clarified that while egg shell calcifications are not specific to pneumoconiosis, they are indicative of an occupationally induced disease. (EX 10 at 37) According to Dr. Wiot, other disease processes, including granulomas, are not related to pneumoconiosis but can coexist with coal mining disease.

Dr. Wiot also commented on Dr. Alexander's interpretation of the Claimant's July 24, 2002 x-ray, which he found to be negative for pneumoconiosis. In his opinion, Dr. Alexander probably found it positive because it is a quality 2 film with high contrast, which "makes things look like they're there that aren't there." (EX 10 at 39)

Dr. Wiot also reviewed the Claimant's April 18, 2002 CT scan, finding no evidence of coal worker's pneumoconiosis. (EX 22 at 25) He did see emphysematous change that he could not appreciate on the Claimant's x-rays. (EX 22 at 25)

[9] Dr. Wiot reviewed the Claimant's chest x-rays dated February 2, 1990, August 11, 1992, October 6, 1992, February 8, 1993. (EX 10 at 20)

Regardless of whether Dr. Wiot had reviewed his reports from the prior claim's x-ray interpretations, his opinion would remain the same.

## DISCUSSION

*Change in Condition of Entitlement*

To prevail in a claim for Black Lung benefits, a claimant must establish that he or she suffers from pneumoconiosis; that the pneumoconiosis arose out of coal mine employment; that he or she is totally disabled, as defined in 20 C.F.R. § 718.204; and that the total disability is due to pneumoconiosis. 20 C.F.R. §§ 718.202-718.204. The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants when the parties' evidence was in equipoise. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.

The instant claim is a "duplicative" or "subsequent" claim because a previous claim was finally denied over one year ago. There is, accordingly, a threshold issue as to whether there are grounds for reopening the claim under 20 C.F.R. § 725.309. A subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present.[10] 20 C.F.R. §§ 725.309(d)(2), (3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309(d)(4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement. In making that determination, I must also consider whether the newly submitted evidence differs "qualitatively" from the evidence submitted during the previously adjudicated claim. *Sharondale Corp. v. Ross*, 42 F.3d 993, 999, 19 BLR 2-10 (6th Cir. 1994).

In this case, the Claimant's previous claim was finally denied for failure to establish the existence of pneumoconiosis. (DX 1) Thus, for purposes of adjudicating the "subsequent" claim, I must first evaluate whether the Claimant has established that he has pneumoconiosis.

*Existence of Pneumoconiosis*

[10] For a miner, the conditions of entitlement include whether the individual (1) is a miner as defined in this section; (2) has met the requirements for entitlement to benefits by establishing pneumoconiosis, its causal relationship to coal mine employment, total disability, and contribution by the pneumoconiosis to the total disability; and (3) has filed a claim for benefits in accordance with this part. 20 C.F.R. §725.202(d) (*Conditions of entitlement: miner*).

Pneumoconiosis is defined, by regulation, as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. The regulations at 20 C.F.R. § 718.203(b) provide that, if it is determined that the miner suffered from pneumoconiosis and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. If, however, it is established that the miner suffered from pneumoconiosis but worked less than ten years in the coal mines, then the claimant must establish causation by competent evidence. *Stark v. Director, OWCP,* 9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.,*9 B.L.R. 1-137 (1986). The claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See, Director, OWCP v. Greenwich Collieries,* 114 S.Ct. 2251 (1995).

Because the current claim was filed after the enactment of the Part 718 regulations, the evidence will be evaluated under standards found in 20 C.F.R. Part 718. The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a). I have independently assessed the evidence under each of these methods.

*X-rays*

To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

The Claimant's July 24, 2002 x-ray was interpreted by Dr. Alexander, who is dually qualified, and Dr. Baker, who is a B reader, and who found the x-ray to be positive for pneumoconiosis. However, Dr. Wiot, who is dually qualified, concluded that it was negative. I find that the additional positive interpretation by Dr. Baker adds probative weight to Dr. Alexander's positive interpretation, and thus I find the July 24, 2002 x-ray is positive for pneumoconiosis.

The Claimant's next x-ray, dated September 30, 2002, was interpreted by two physicians. Dr. DePonte, who is dually qualified, concluded that it was positive for pneumoconiosis; Dr. Wiot, who is also dually qualified, determined it was negative. Given the similar credentials of these physicians, I find these interpretations to be in equipoise, and thus not sufficient to establish pneumoconiosis.

Dr. Wheeler, who is dually qualified, interpreted the Claimant's January 27, 2003 x-ray, finding it to be negative. There are no contrary interpretations, and thus I find that this x-ray is negative for pneumoconiosis.

The Claimant's April 28, 2004 x-ray was interpreted by Dr. Patel, who found it to be positive, and by Dr. Wiot, who found it to be negative. Given the similar credentials of these physicians, I find that these interpretations are in equipoise, and thus this x-ray is not positive for pneumoconiosis.

Dr. Rosenberg, who is neither a B reader nor a board certified radiologist, interpreted the Claimant's June 15, 2004 x-ray, finding it to be negative for pneumoconiosis. There is no contrary evidence, and thus I find that the June 15, 2004 x-ray is negative for pneumoconiosis.

In sum, of the five x-rays submitted, one is positive, two are inconclusive, and two are negative. I have also considered the qualifications of the physicians who interpreted the x-rays. I find that the Claimant has not established the existence of pneumoconiosis by a preponderance of the x-ray evidence.

*Biopsy or Autopsy Evidence*

Under § 718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. This section requires the procedure to be conducted and reported in compliance with § 718.10, which requires the submitted report to include "a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung." The regulations also dictate that "[a] finding . . . of anthracotic pigmentation, however, shall not be sufficient, by itself, to establish the existence of pneumoconiosis." 20 C.F.R. § 718.202(a)(2).

In this case, the Claimant underwent a biopsy of a paratracheal lymph node located in his mediastinum on April 26, 2002. Dr. Colquitt examined the pathological slides and diagnosed sinus histiocytosis, with carbonaceous pigment deposition and fibrocalcific anthrasilicotic nodules.

Dr. Oesterling, who examined the pathological slides, found that the lymph nodes contained minimal black and anthracotic pigmentation. In the left aspect, he found histiocytes containing modest quantities of black pigment with elongated needle-shaped bright silicate crystals and smaller less birefringent silica crystals. Dr. Oesterling stated that the origin of these abnormalities was coal dust. But he believed that if the Claimant had inhaled significant quantities of coal dust, the lymph nodes would be enlarged and markedly blackened, and would contain extensive areas of fibrosis.

Dr. Foster, relying on Dr. Colquitt's analysis, wrote in his report that the biopsy showed multiple calcified mediastinal and hilar lymph nodes consistent with old histoplasmosis or silicosis. In his deposition, he explained that the biopsy showed some scarring changes, or carbonaceous pigment deposition and fibrocalcific anthrasilicotic nodules, which were part of the Claimant's paratracheal lymph node.

A finding of pneumoconiosis requires evidence that the lung tissue has reacted to embedded coal deposits. In other words, the presence of black pigment in the lungs,

standing alone, is not sufficient to support a finding of pneumoconiosis. However, observations of black pigment *with associated fibrosis* qualify as a diagnosis of pneumoconiosis, and satisfy the legal definition of pneumoconiosis. *See, Hapney v. Peabody Coal Co.*, 22 B.L.R. 1-106 (2001)(en banc). Diagnoses of pulmonary anthracosis have been held to be the equivalent of a diagnosis of pneumoconiosis. *Dagnan v. Black Diamond Coal Mining Co.*, 994 F.2d 1536 (11th Cir. 1993); *Bueno v. Director*, OWCP, 7 B.L.R. 1-337 (1984); *Smith v. Island Creek Coal Co.*, 2 B.L.R. 1-1178 (1980); *Luketich v. Bethlehem Mines Corp.*, 2 B.L.R. 1-393 (1979). The Sixth Circuit has held that the administrative law judge must consider biopsy evidence which indicates the presence of anthracotic pigment. *Lykins v. Director, OWCP*, 819 F.2d 146 (6th Cir. 1987). However, in *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995), the Sixth Circuit held that a finding of pigmentation described as "yellow-black consistent with coal pigment" was insufficient, standing alone, to support a finding of pneumoconiosis.

In this case, Dr. Colquitt, who first examined the biopsy specimen, diagnosed sinus histiocytosis with carbonaceous pigment deposition, and fibrocalcific anthrasilicotic nodules. These findings clearly identify the presence of anthracotic pigment, with associated fibrosis. Dr. Oesterling also examined the slides, and although he characterized the black pigment he found as modest in amount, he also stated that it had elicited fibrosis (albeit minimal), and a fibronodular response to silica crystals.

I find that the observations of black or carbonaceous pigment by Dr. Colquitt and Dr. Oesterling, which were coupled with a fibrotic response, are sufficient to satisfy the legal definition of pneumoconiosis. I note that the Board has held that anthracosis that is found in lymph nodes may be sufficient to establish the existence of pneumoconiosis. *See, Taylor v. Director, OWCP*, BRB No. 01-0837 BLA (July 30, 2002) (unpublished) (The Board remanded for a determination of whether a physician's conclusion on autopsy that there was minimal anthracosis in the mediastinal lymph nodes met the legal definition of pneumoconiosis at 20 C.F.R. §718.201 (2001).

Accordingly, I find the Claimant has established the existence of pneumoconiosis by the biopsy evidence.[11]

*Allowable Presumptions*

Section § 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, none of these presumptions apply. The presumption of § 718.304 does not apply because there is no indication Claimant has complicated pneumoconiosis. The presumption of § 718.305 does not apply to claims filed after January 1, 1982. Section 718.306 only applies to survivor claims. Therefore, I find Claimant cannot establish pneumoconiosis under § 718.202(a)(3).

[11] As the Claimant worked for more than ten years as a coal miner, he is entitled to the regulatory presumption, which has not been rebutted, that his pneumoconiosis arose from his coal mine employment.

*Reasoned Medical Opinion*

The Claimant can also establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.,* 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See,* 20 C.F.R. § 718.107, *Hoffman v. B&G Construction Co.,* 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.,* 7 B.L.R. 1-295 (1984). A report which is better supported by the objective medical evidence of record may be accorded greater probative value. *Minnich v. Pagnotti Enterprises, Inc.,* 9 B.L.R. 1-89, 1-90 n.1 (1986); *Wetzel v. Director, OWCP,*8 B.L.R. 1-139 (1985).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra.* Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder of fact to decide. *Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP,* 11 B.L.R. 1-135 (1988). An equivocal opinion, however, may be given little weight. *Justice v. Island Creek Coal Co.,* 11 B.L.R. 1-91 (1988); *Snorton v. Zeigler Coal Co.,* 9 B.L.R. 1-106 (1986).

In evaluating conflicting medical reports, as with x-ray analysis, it may be appropriate to give more probative weight to the most recent report. *Clark v. Karst-Robbins Coal Company,* 12 BLR 1-149 (1989)(en banc). At the same time, "recency" by itself may be an arbitrary benchmark. *Thorn v. Itmann Coal Company*, 3 F.3d 713 (4th Circuit 1993). Finally, a medical opinion may be given little weight if it is vague or equivocal. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Circuit 1995), *Justice v. Island Creek Coal Company,* 11 BLR 1-91 (1988).

In this case, Dr. Rasmussen concluded that the Claimant has pneumoconiosis. He based his opinion on the Claimant's positive x-ray and his history of coal mine employment. However, I have found that the x-ray evidence does not establish the existence of pneumoconiosis. Dr. Rasmussen did not discuss the biopsy findings. As the only other basis for Dr. Rasmussen's opinion is the Claimant's history of coal dust exposure, I find that his conclusion is not supported by sufficient medical evidence, and is entitled to little weight.

Dr. Rasmussen also referred to medical articles in his report discussing the possible relationship between coal dust exposure and interstitial lung disease. However, he failed to establish any link between the Claimant's symptoms and the presence of interstitial lung disease.

Dr. Baker concluded that the Claimant has coal workers' pneumoconiosis, based on his positive x-ray and his history of exposure to coal mine dust. Again, however, I have found that the x-ray evidence does not establish the existence of pneumoconiosis. Dr. Baker did not review the biopsy findings. Since the only other basis for Dr. Baker's opinion is the Claimant's history of coal dust exposure, I find that his conclusion is not supported by sufficient medical evidence, and is entitled to little weight.

Dr. Baker also concluded that the Claimant has chronic obstructive pulmonary disease, based on the results of his pulmonary function studies, due to his exposure to coal dust, as well as his history of smoking. But he did not provide any rationale or supporting medical evidence for this conclusory opinion, and I find that it is entitled to little weight.

Dr. Foster concluded that the Claimant has pneumoconiosis, based on the x-ray evidence and the results of the Claimant's lymph node biopsy. He acknowledged that he could not tell if the changes on the Claimant's x-ray were due to lupus or pneumoconiosis. However, he noted that the Claimant's biopsy showed fibrocalcific anthrasilicotic nodules, which were caused by occupational and inhalational exposure, findings that confirmed his diagnosis of coal worker's pneumoconiosis. While I have concluded that the x-ray evidence does not establish the existence of pneumoconiosis, I have found that the results of the mediastinal lymph node biopsy establish pneumoconiosis. Thus, I find that Dr. Foster's opinion is supported by the objective medical evidence.

Dr. Repsher concluded that the medical evidence weighed against a finding of pneumoconiosis. However, for a number of reasons, I am not persuaded by his opinions. Dr. Repsher relied on the preponderance of the negative x-ray interpretations, which is in accord with my findings on the x-ray evidence. However, he found no histologic evidence of coal workers' pneumoconiosis, despite the findings by Dr. Colquitt and Dr. Oesterling on examination of the Claimant's mediastinal lymph node. Dr. Repsher, who did not examine the slides, did not dispute the findings by Dr. Colquitt and Dr. Oesterling. He simply does not believe that a diagnosis of pneumoconiosis can be made based on a lymph node biopsy. However, while Dr. Repsher may be correct from a purely clinical standpoint, as discussed above, a finding of black pigment with associated fibrosis in a mediastinal lymph node in fact meets the legal definition of pneumoconiosis.

Dr. Repsher also acknowledged that the Claimant has chronic obstructive pulmonary disease, which could be due to his coal dust exposure. But he discounted the Claimant's exposure to coal dust as a factor in his COPD, because "statistically," it was unlikely, as COPD due to coal dust exposure generally resolves within 12 months after cessation of coal dust exposure. While Dr. Repsher did not go so far as to say that chronic obstructive pulmonary disease is not caused by pneumoconiosis or exposure to coal dust, his opinions are not consistent with the legal concept that pneumoconiosis is a progressive condition that can manifest itself years after a miner leaves the mines.[12]

[12] Indeed, the Employer acknowledged its dispute with Section 725.309(d), which it argues is based on the "Department of Labor's mistaken belief that in any case legal pneumoconiosis can be latent and

Dr. Rosenberg likewise concluded that the Claimant does not have pneumoconiosis. He relied on the negative x-ray interpretations, pulmonary function test results, and arterial blood gas studies to form his conclusion. Dr. Rosenberg felt that the Claimant would not have developed any latent or progressive pneumoconiosis after he left the mines in 1991. He also felt that the findings of anthracosis or silicosis in the mediastinal lung tissue did not equate to either medical or legal pneumoconiosis. Again, while Dr. Rosenberg may be correct from a purely clinical standpoint, I have found that the biopsy findings are sufficient to meet the legal definition of pneumoconiosis. As with Dr. Repsher, I have given Dr. Rosenberg's opinions somewhat less weight because he does not believe that pneumoconiosis is a latent or progressive condition.

I rely on the report by Dr. Foster, which I have found to be well-reasoned and documented by the objective medical evidence. I find that the Claimant has established the existence of pneumoconiosis by the medical report evidence.[13]

Finally, I have considered all of the new evidence on the issue of pneumoconiosis, like and unlike, and I find that the Claimant has established the existence of pneumoconiosis. Accordingly, he has established a material change in condition, and he is entitled to consideration of his claim on the merits.

*Merits of the Claim*

As discussed above, I have found that the newly submitted evidence establishes the existence of pneumoconiosis. I have reviewed the record as a whole, and I note that in the Claimant's most recent claim, there were twenty-six interpretations of six-rays. Only six were positive for pneumoconiosis. The results of a biopsy were negative for pneumoconiosis. The medical opinions of Drs. Baker and Anderson, who diagnosed pneumoconiosis, depended on positive x-ray interpretations, whereas the preponderance of the x-ray evidence was negative for pneumoconiosis.

However, while the evidence from the previous claim, standing alone, is not sufficient to establish the existence of pneumoconiosis, I find that, considering all of the medical evidence, the Claimant has established the existence of pneumoconiosis. I rely on the concept that pneumoconiosis is a progressive condition, and thus the lack of sufficient evidence of pneumoconiosis in the previous claim does not negate a finding of pneumoconiosis with the consideration of the new evidence. I have concluded that the preponderance of the x-ray evidence does not establish the existence of pneumoconiosis. However, the results of the Claimant's mediastinal lymph node biopsy, along with Dr. Foster's report, are sufficient to establish the existence of pneumoconiosis.

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progressive absent further coal dust exposure." The Employer challenges this section facially, and as it applies to this case. Employer's Brief at 18.

[13] Dr. Wiot interpreted the Claimant's April 18, 2002 CT scan as showing no evidence of pneumoconiosis. I have concluded that the x-ray evidence does not establish pneumoconiosis; Dr. Wiot did not review medical evidence other than x-ray and CT scans, and thus his report is not relevant in weighing the medical opinions.

In order to be entitled to benefits, the Claimant must also establish that he is totally disabled due to pneumoconiosis. The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. § 718.204(b)(1).

Total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right-sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment. 20 C.F.R. § 718.204(b)(2). Furthermore, under 20 C.F.R. § 718.304, if a claimant can establish the existence of "complicated pneumoconiosis," an irrebuttable presumption arises that the claimant is totally disabled due to pneumoconiosis. For a living miner's claim, total disability may not be established solely by the miner's testimony or statements. 20 C.F.R. § 718.204(d)(5).

I find that the Claimant has established that he has a totally disabling respiratory or pulmonary impairment. The results from two out of the three recent pulmonary function tests qualify for disability under the regulatory presumptions. In addition, both of his arterial blood gas studies qualify for the presumption of disability. Lastly, all of the reporting physicians agree that the Claimant is unable to work in coal mines or to endure similarly arduous labor in a dust free environment. Accordingly, I find that the Claimant has established he is totally disabled by a respiratory or pulmonary impairment.

But the Claimant must also establish that his totally disabling respiratory or pulmonary impairment is due, at least in part, to his pneumoconiosis. I find that the Claimant has not met his burden on this issue. Dr. Baker, who examined the Claimant for the Department of Labor, concluded that, based on the results of his pulmonary function and arterial blood gas studies, he did not have the respiratory capacity to perform his previous coal mining work or similar work. He attributed the Claimant's respiratory impairment to his exposure to coal dust, as well as his history of cigarette smoking, and possibly his cardiac condition. But he did not explain how the Claimant's exposure to coal dust played a part in his respiratory impairment. Nor did Dr. Baker have the opportunity to review the results of the Claimant's mediastinal lymph node biopsy, which are the basis for my finding that the Claimant has established the existence of pneumoconiosis.

Dr. Repsher agreed that the Claimant's arterial blood gas results showed that he had hypoxemia, but he believed that this was caused by the Claimant's left ventricular congestive heart failure, not his exposure to coal mine dust. He also agreed that the Claimant has chronic obstructive pulmonary disease, but he felt that it was due to an

etiology other than exposure to coal mine dust. Dr. Rosenberg also agreed that the Claimant cannot perform his previous coal mine employment or similar labor. He acknowledged the Claimant's worsening oxygenation, but stated that it was related to underlying linear interstitial lung disease, as shown on x-ray, which was caused by his lupus, not his exposure to coal mine dust. He also felt that the Claimant's chronic obstructive pulmonary disease was not affected by his exposure to coal mine dust. As discussed above, the reliability of Dr. Repsher's and Dr. Rosenberg's opinions is adversely affected by their belief that obstructive lung disease due to coal dust exposure is not a latent or progressive condition. Nevertheless, their opinions do not affirmatively establish that the Claimant's respiratory impairment is due to his pneumoconiosis, or to his exposure to coal dust.

Dr. Rasmussen concluded that there are multiple possible causes of the Claimant's disabling lung disease, including his coal mine dust exposure and cigarette smoking, both of which cause lung tissue destruction leading to emphysema. Citing to medical articles, he stated that the Claimant's coal mine dust exposure must be considered as a primary and possibly secondary cause of his disabling lung disease. However, other than citing to medical articles, Dr. Rasmussen did not provide the basis for his conclusions – he did not explain how the test results were consistent with a finding of coal mine dust induced lung disease, or how the findings in the medical articles specifically applied to the Claimant's test results and findings. In other words, while the articles cited by Dr. Forehand may in fact document that disabling lung disease can be caused by exposure to coal dust, Dr. Forehand did not describe the specific findings in the Claimant's case that were consistent with the studies in these articles, or how the mechanics of his respiratory impairment were consistent with coal dust exposure as a causative factor. I find that his opinions are conclusory, and not adequately reasoned or supported by the objective medical evidence, and I accord them limited weight.

None of the physicians have even suggested a connection between the minimal amount of pneumoconiosis found in the Claimant's mediastinal lymph node and his hypoxemia and chronic obstructive pulmonary disease.

I find that the Claimant has not established by a preponderance of the reliable and persuasive medical evidence that his totally disabling respiratory impairment is due to pneumoconiosis.

## CONCLUSION

Based on the foregoing, I find that the Claimant has established a material change in condition, that is, that he has pneumoconiosis, and a totally disabling respiratory impairment. But he has not established that he is totally disabled due to pneumoconiosis. Thus, he is not entitled to benefits under the Act.

## ORDER

Accordingly, IT IS HEREBY ORDERED that the claim of Silas Mullins for benefits under the Black Lung Benefits Act is DENIED.

SO ORDERED.

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LINDA S. CHAPMAN
Administrative Law Judge

## ATTORNEY'S FEES

The award of an attorney's fee is permitted only in cases in which the Claimant is found to be entitled to benefits under the Act. 20 C.F.R. § 725.367. Since benefits are not awarded in this case, the Act prohibits the charging of attorney's fees to the Claimant for services rendered in pursuit of this claim.

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision